HEALTH INFORMATION TECHNOLOGY COMMISSION

Minutes for September 2013 Meeting

Date: Thursday, September 19, 2013
1:00 pm – 4:00 pm

Location: MDCH
1st Floor Capitol View Building
Conference Room B & C
201 Townsend Street
Lansing, Michigan 48913

Commissioners Present:

Gregory Forzley, M.D., Chair
Thomas Lauzon
Mark Notman, Ph.D.
Patricia Rinvelt
Irita Matthews
Nick Lyon
Larry Wagenknecht, R.Ph.
Orest Sowirka, D.O.
Jim Lee
Michael Chrissos, M.D.
Robert Milewski
David Behen, CIO (Phone)

Commissioners Absent:

Michael Gardner

Staff:

Meghan Vanderstelt
Kimberly Bachelder
Phillip Kurdunowicz

Guests:

Patrick Sheehan
Kristy Tomasko
Bill Riley
Jeff Livesay
Tim Pletcher
Angela Vanker
Andrew Wright
Brian Burks
Theresa Cradduck
James Gartung
Elizabeth Reese
Leslie Asman
May Al-Khafaji
Umbrin Ateequi
Cynthia Green Edwards
Lynda Zeller
Randy McCracken
Andrea Walrath
Lara Barrera
Victoria Oliver
Rick Wilkening
Randy Padgett
Jonathan Landsman
KatyAnn Zimbelman
Carmen Redwine
Darrell Dontje

Minutes: The regular monthly meeting of the Michigan Health Information Technology Commission was held on Thursday, September 19, 2013 at the Michigan Department of Community Health with 12 Commissioners present.

A. Welcome and Introductions

1. Chair Gregory Forzley, M.D. called the meeting to order at 1:06 pm.
2. Commissioner Updates
    a. Commissioner Mathews noted the signing of the Healthy Michigan act into law.
    b. Commissioner Rinvelt voiced concerns as to whether the State has the IT capacity to handle the Medicaid expansion under the Healthy Michigan Act.
        i. Commissioner Lyon said that there was some concern at the State about the technological capacity, but there had not been any specific analysis done on this yet.
        ii. Chair Dr. Forzley restated the question of whether the technology infrastructure of the State would be capable of handling the influx of newly eligible Medicaid patients. Commissioner Lauzon stated his opinion that this would be the case.
    c. Commissioner Lyon went into more detail on the successful passage of Public Act 107-Healthy Michigan.

B. Review and Approval of 9/19/2013 Meeting Minutes

1. The commission approved the minutes at 1:16 pm.

C. HIT-HIE Update

1. HIT-HIE Dashboard
    a. Meghan Vanderstelt presented on the details of the HIT-HIE dashboard. The dashboard will be available online for review after the meeting.
    b. Chair Dr. Forzley explained that the point of [Michigan Care Improvement Registry] was to enable providers to search immunization histories. Currently, providers are able to electronically report immunizations to the MCIR but cannot yet "pull" the patient immunization data out of MCIR.
    c. Chair Dr. Forzley noted that the M-CEITA clientele population is less than 10% of EPs in state and was curious whether there was any information on the rest of the clientele population. Mrs. Vanderstelt said she would look into this information.
    d. Mrs. Vanderstelt noted that Beacon is nearing the end of the American Recovery and Reinvestment Act grant period (September 30, 2013). Beacon will be providing a final round-up of activity for their grant-end report.
2. Advisory Committee Reviewing the Public Health Code
    a. Their first meeting was last month, and the next one is scheduled for October 10.
    b. The commission inquired about the process of offering feedback. Commissioners Rinvelt and Dr. Notman advised that a set of recommendations coming from the HIT Commission as a whole could lend more weight.
    c. Commissioner Rinvelt asked whether Mrs. Vanderstelt would be the collection point for joint effort, to which Mrs. Vanderstelt agreed. She said that she would take either collaborative or individual submissions. Chair Dr. Forzley declared that the Commission would submit both individual and group-endorsed comments.
3. State Innovations Model (SIM) Grant
    a. Mrs. Vanderstelt explained that the SIM HIT-HIE Sub-workgroup is putting together a draft recommendations sheet that identifies current initiatives and support and highlights the gaps where policy could help. The goal is to ensure that all initiatives were leveraged and to provide an As-Is/To-Be plan to ensure alignment with federal partners. The federal partners include the Centers for Medicare and Medicaid Innovation (CMMI) as well as CMS.

i. Commissioner Rinvelt asked about when the commission would see the outcome.
ii. Mrs. Vanderstelt replied that the recommendations sheet will be sent to the larger SIM Group, and the final version would go into the State Health Innovation Plan (the final work product of the SIM Planning Grant project). Michigan is currently a Planning State.
iii. Commissioner Wagenknecht asked when the deadline for this project would be. Mrs. Vanderstelt said that the current one was October 1, but the state had requested a delay until November 1. She was unsure whether that extension had been approved or not.

4. Cyber Security
    a. Mrs. Vanderstelt explained that the recently created Cyber Security Council discussed roles, workgroups, and procedures at its recent meeting.
    b. Their next meeting will be October 25.
5. Michigan HIMSS Conference
    a. Ms. Vanderstelt recently attended this conference. The main highlights of discussion were the new HIPAA Rule changes and HIT Workforce Development.
    b. A slide deck of presentations will be sent to the Commission.

D. Update on Consent Management from the Privacy Workgroup

1. Mr. Bill Riley, CIO for Oakland County Community Mental Health, presented on the work of the MiHIN Operations Advisory Committee Privacy Workgroup. The slides will be available online for review after the meeting.
2. Chair Dr. Forzley asked about how individuals should identify large integrated networks on their consent form. Mr. Riley said that this answer had not yet been defined, but the goal was to avoid going too broad or too narrow.
3. Commissioner Lyon asked if the workgroup was considering HIPAA requirements in this form. Mr. Riley replied that this was the case and explained that HIPAA is actually a lower standard of consent than the Michigan Mental Health Code.
4. Commissioner Milewski asked where the consent forms would be stored. Mr. Riley replied that ultimately, the forms would be stored electronically, with an electronic signature from the patient that would be verifiable. It would also be possible to scan in the paper form of the document, possibly for storage in an EMR.
5. Commissioner Lee noted the standardized 1-year expiration date and asked what the motivation behind that was. Mr. Riley responded that this had become common practice among behavioral health providers, one of the few common things among existing BHI sharing consent documents.
6. Commissioner Rinvelt asked if this form would be available in other languages. Mr. Riley said that this would be the case.
7. Commissioner Mathews inquired as to the significance of the bolded language. Mr. Riley responded that it was simply to draw attention to that specific language.
    a. Commissioner Mathews followed up by asking if this language meant that patients could pick and choose which of the three information types listed above they would consent to share. Mr. Riley replied in the negative: the individual must choose to share all of the listed information or none of it.
    b. Mr. Riley continued by saying that research had been performed on this. There is a possibility of lack of signatures, but at most 10% will not sign a consent form because of this inability to segment consent on the three information types listed above. Furthermore, in a care coordination environment as is available in certain

programs, it will be virtually a requirement to sign as a condition of care. This will allow consented sharing of all this relevant information among the providers included in the care coordination program.

8. Commissioner Rinvelt noted that there could and should be some lower-level manual consents available in the event that the patient didn't wish to sign this standardized one.
9. Ms. Andrea Walrath of M-CEITA asked if providers have to destroy the patient information after the consent expires. Mr. Riley answered no, since it had already been released and become part of the other provider's medical record for that patient.
10. Ms. Cynthia Green Edwards of the Office of Medicaid HIT voiced a concern: "Any other medical information" as used in the standardized consent form looks very similar to the HIPAA information sharing consent form. That language states that information could be shared for payment/treatment/operations. The BHI sharing consent form could be confusing with "physical" health data. Any confusion with the standard HIPAA health information sharing consent form may mislead patients into believing that none of their medical data will be shared if they do not sign this BHI consent form. Mr. Riley said that the privacy workgroup would look into this.
11. Commissioner Mathews reiterated that the form has some linguistic elements of a regular HIPAA authorization. Mr. Riley replied that this form was not by design meant to replace the HIPAA sharing consent from. He went on to say that this document being presented would be used to grant Physical Health providers access to Mental and Behavioral Health information, not so much for Behavioral Health Providers to gain access to physical health information. Commissioner Mathews again noted the confusion around this form looking like a HIPAA authorization. Mr. Riley explained that the Privacy Workgroup built the form to be very generic so that physical health providers requesting physical health information sharing consent could theoretically use this form also.
12. Mr. Tim Pletcher of MiHIN asked why the "Revoke all consent" option should be available. Mr. Riley replied that the workgroup felt that if the patient wants to revoke all consent, they should be able to do so efficiently.
13. Chair Dr. Forzley requested a practical application of the workflow surrounding using this form for HIPAA/Treatment consent. Mr. Riley obliged with the following:
    a. A Case manager wants to share information with a Primary Care Physician. The Care manager can load a consent form into the system with an electronic signature. The electronic system will recognize the e-signature and exchange information appropriately.
    b. The Primary Care Physician, once loaded into the system and identified as being part of the signed consent, can now electronically request a Continuity of Care Document (CCD). The CMH system will check for the existence of a valid consent without manual intervention.
    c. Chair Dr. Forzley asked how this form is different than a general authorization. Mr. Riley replied that lots of patient education is needed. Guidelines are coming on management and support of the use of these consent forms. A supporting document is needed, written at a 4th/5th reading level to ensure proper communication with all patients on the nuances of this consent form.
14. Commissioner Lee asked whether a physical health provider could use this form to receive information from a behavioral health provider. Mr. Riley answered in the affirmative
15. Mrs. Linda Zeller of the Behavioral Health and Developmental Disabilities Administration at MDCH said that this standardized consent form will solve a huge problem from the perspective of a primary care physician because the community mental health consent form

had to be used due to the higher bar for consent to exchange BHI. This could vary from CMH to CMH and made matters difficult for the PCP.

16. Commissioner Rinvelt asked if the Privacy Workgroup knew of any other entities with this problem, especially whether consent education programs were available.
    a. Mr. Riley responded that behavioral health providers in Michigan all have different approaches. The workgroup had not yet looked nationwide for solutions, but took the stance that they needed the standard form to be approved before they could proceed with education.
    b. Mr. Jeff Livesay from MiHIN, however, noted that the State of Rhode Island has an opt-in consent model both for BHI exchange and for physical health information exchange. The Privacy Workgroup is reaching out to Rhode Island on education techniques, so as not to reinvent the wheel on consent education.
17. Commissioner Dr. Notman wanted to clarify whether this standard consent form would require the use of an electronic medical record. Mr. Riley said that providers could still use paper versions of the form.
18. Commissioner Dr. Notman then asked about the current saturation of EMRs in behavioral health. Ms. Zeller stated that almost 100% of behavioral health professionals in Michigan have some sort of EMR. The depth of that EMR capacity may vary. Commissioner Dr. Notman noted that the infrastructure is pretty much already in place to implement this system of consent forms. It was also noted that even the major behavioral health provider alliance and CMHs have endorsed this standardized consent form.
19. Mr. Pletcher rose to explain that the workgroup was not trying to add to a consent quagmire, but to simplify the one that currently exists. He reiterated that this issue was the highest priority raised by the behavioral health community as a barrier to exchanging information among themselves and with the physical health community. Mr. Riley added that this standard consent form was better than all providers going 100 different directions on how to handle BHI sharing consent.
20. Ms. Edwards noted that Medicaid has modified its eligibility application form so that similar language would become a requirement for eligibility. Michigan Medicaid is still working with CMS to make sure that this language is in compliance with federal law.
21. Commissioner Lyon asked if there were any other efforts on standardizing consent in the state, specifically to determine if there would be any conflict/contrast/other concerns raised by those efforts.
    a. Mr. Riley noted the upcoming discussion on efforts by the Department of Corrections. The two groups are trying to make sure that their efforts are in sync. This issue separately “bubbled up” from the CMH and Corrections communities.
    b. Commissioner Lyon pressed to determine whether any other efforts were going on around standard consent. Mr. Riley stated that the PWG was unaware at this time of any other efforts.
22. Commissioner Mathews inquired how long the review period would be on this consent form for the HIT Commission, especially relating to reviews of Public Health Code. Mr. Livesay explained that the review period would begin right away, and recommendations should be sent to the Privacy Working group. The commission posed the question of what precisely would be voted on at the October Meeting.
23. Mr. Pletcher stated that his document serves as model and supports the 4 use cases listed above. The Privacy Working Group wants the Commission to encourage use of this form. A full consensus from the Commission and from MDCH is necessary to allay fears from behavioral health providers that this form is a legitimate way to authorize exchange.

24. Ms. Zeller added that standardized consent form language exists already in behavioral healthcare, so this document is not as big a leap for patients and providers. The leap is making the connection with physical health, so physical health care providers do not manage multiple CMH consent forms.
25. Commissioner Lyon asked if there were any limitations on this consent language from the Michigan Mental Health Code. Ms. Zeller responded that the language was structured to conform to the 42 CFR standard, which is the highest bar for patient consent, so there would not be any limitations from state law.
26. There had been some concern that 42 CFR actually prohibited the use of this consent language, but it was discovered that 42 CFR does permit this sort of standard consent form for exchange between behavioral and primary care providers. The plan is to take the current process for obtaining consent for this exchange, and making it standard, so it can eventually be done electronically.
27. Commissioner Lyon then followed up to ask whether the courts and patient advocates had been involved in the review. Ms. Zeller replied that advocates had been involved in mental health piece.
28. Mr. Pletcher then asked the commission to consider and explain what would be necessary to have this consent form approved as a standard.
29. Commissioner Lee asked to clarify whether this consent standardization would be a voluntary effort as opposed to a mandate, and Mr. Pletcher responded that it was indeed the former. He elaborated to say that there was no need to try to change existing law, just to use what was in place to find a workable standard. He then described how CMH risk management personnel desired a sense of safety from an endorsed, standardized consent form to use in this process of sharing with physical health providers.
30. Mr. Riley added that this consent form would not merely apply to Medicaid patients, but covers a broad umbrella of patients to give their consent to this exchange.
31. The “ask” is for the Commission’s endorsement to give it to the MDCH Director for his endorsement as a standard.
32. Chair Dr. Forzley summarized the above discussion:
    a. Use of this form would be a voluntary effort.
    b. The Behavioral Health community wants a tool that is standardized, and to make their process more consistent.
    c. Chair Dr. Forzley then asked whether private mental health providers had been included in the discussion. It was explained that private mental health providers are included in provider alliances, such as those that work with Michigan Health Connect. The commission urged the Privacy Working Group to make sure that they received input from this community. Ms. Zeller noted that there are lots of projects on the table for these groups to discuss, but the Privacy Workgroup will update the private mental health groups on their progress just to be sure.
33. Commissioners and other stakeholders were directed to send their follow-up comments via email to the MOAC Privacy Workgroup.

E. Consent Management in Corrections

1. Mr. Andrew Wright presented on behalf of the efforts of Judge Bell and the Mental Health Diversion Council to produce a consent form. The Mental Health Diversion Council is an advisory body to the Governor within MDCH that is charged with determing what regulatory and statutory requirements are needed to ensure that care is not interrupted between the corrections system and external mental/behavioral health. The council consists of judicial representatives, MDCH, attorneys, mental health care practitioners, etc.

2. To facilitate this plan for diversion, the Council is looking to leverage the health IT infrastructure, including MiHIN, to exchange relevant information.
3. Mr. Wright displayed the Mental Health Diversion Council's version of a BHI Sharing Consent Form, which will be available online for review after the meeting.
4. Mr. Wright recommended that the discussion with MHD Council be continued and that someone should be available at the next PWG/MHD Council meetings to establish a use case. If possible, one standardized consent form also applicable to Behavioral Health/Physical Health sharing would be produced.
5. Commissioner Rinvelt asked if there were a plan in place to synchronize the two efforts of the MHD Council and the PWG. Mr. Wright answered that the MHD Council bringing this to HITC attention was part of the plan.
6. Ms. Zeller noted that the MHD Council wanted to support a secure server model, where CMH records and Corrections records would all be "dumped" into one secure server. The two groups would like to determine whether their consent management efforts could be merged first. If not, the MHD Council will proceed on its own, as a file transfer protocol (FTP) model is very different than what is taking place for health information exchange. The groups are exploring the possibility of one merging path for their exchange efforts.
7. Commissioner Lyon observed that the two groups' plans look very different. He questioned whether the groups truly had the same purpose for consent or different purposes for different populations.
    a. Mr. Wright replied that the purpose was the same: to develop a unified consent form and process for behavioral health information sharing. The differences arose from two communities and populations with their own perspectives.
    b. Ms. Zeller added that the MHD Council was driven by county sheriffs, jails, and the courts as opposed to behavioral health professionals.
8. Chair Dr. Forzley wondered about the practicality of Jail-CMH sharing. Mr. Wright answered that this was a practical idea. He added that the consent form very different in a given court versus what sheriffs and other law enforcement entities use
9. Mr. Livesay speculated whether this could be a special case of the standard form, potentially making the page presented by the Mental Health Diversion Council a special use case. Mr. Livesay and Mr. Wright also discussed resolving the issue of the more specific checklist of information to share by making that detailed checklist an addendum only to explain what information might be shared.
10. Commissioner Lauzon voiced his opinion that these two consent efforts should be merged if at all possible. He also asked what would happen if Behavioral Health were to have issues electronically with any plan proposed by the MHD Council. Mr. Wright stated that the technology questions illustrate how early the conversations are.
11. Mr. Pletcher summarized by saying that the State needs to make sure that its standards for Privacy and Security are consistent with National standards. The practical goals are to minimize duplication and remove any unnecessary standards. He noted that the MiHIN Privacy Working Group would be making rounds at appropriate Governor's Commissions to see if there would be any similar opportunities for collaboration.
12. Chair Dr. Forzley asked whether Judge Bell would be available in October. Mr. Wright said this might be possible. Mrs. Vanderstelt said that she could schedule either Judge Bell or another MHD Council representative.
13. Commissioner Wagenknecht asked whether the simple inclusion of a finalized Corrections Facilities Use Case into the Privacy Working Group's use cases would be sufficient to resolve any issues. Ms. Zeller explained that the two groups met for the first time two weeks prior.

The two communities still need to meet further and make sure that such a use case would be appropriate to address all stakeholder concerns.

F. Admit, Discharge, Transfer (ADT) Statewide Initiative Update

1. Dr. Tim Pletcher presented on the ADT use case on behalf of MiHIN. The slides will be available online for review after the meeting.
2. Commissioner Lyon asked if the use case categories had always been the same. Mr. Pletcher responded that they had.
    a. Commissioner Lyon followed up by asking who develops the Use Cases.
    b. Mr. Pletcher explained that the MOAC Use Case workgroup-authors, defines, and vets use cases. Their final output is a use case agreement.
    c. MiHIN approves Use Cases and informs the HIT Commission as they are doing now.
3. Chair Dr. Forzley added that the basis of the use cases could be found in the Connectivity to Care document from the mid-2000s that served as the basis for MiHIN.
    a. Commissioner Lyon then explained that he was trying to understand what precisely the HIT Commission, MDCH, and MiHIN do in the development of use cases.
    b. Ms. Edwards from Medicaid said that the HIT Commission looks at all MDCH initiatives and helps MiHIN incorporate them into particular use cases.
4. Commissioner Lauzon asked what information is shared in the "Share Clinical Information with Hospitals" use case. Mr. Pletcher explained that, for example, an Admit, Discharge, Transfer (ADT) message can provide notifications of an emergency department admission to a primary care provider within 24 hours. This allows the PCP to provide timely follow-up.
5. Mr. Pletcher added that he had been instructed by the MiHIN board to pursue this goal: anyone in the State should be able to generate and share a valid Use Case.
6. Chair Dr. Forzley asked how Syndromic Surveillance messages are used for the benefit of the HIT Commission. Mr. Pletcher explained that many providers already send voluntary Syndromic messages to the State. Syndromic Surveillance is a public health early warning system. Chair Dr. Forzley noted that the use of the term "Admission" to an Emergency Department could be confusing, as patients are usually only "admitted" to inpatient care.
    a. Mr. Pletcher clarified that whenever patients are moved, the relevant EHR computers generate a HL7 ADT message.
    b. Commissioner Dr. Notman asked what is done with the messages. Mr. Pletcher answered that after an ADT message is sent, it gets deleted by MiHIN. Mr. Livesay clarified that Commissioner Dr. Notman was referring to syndromic messages. Thus advised, Mr. Pletcher explained that these eventually go to the Michigan Syndromic Surveillance System (MSSS).
7. Commissioner Lyon asked to clarify that if an encounter was self-pay, there is no ADT message sent to the payer.
    a. Commissioner Lee said that the patient must say so specifically, and Mr. Pletcher added that this is only an option if the charges go above a patient's plan deductible. Commissioner Mathews concurred.
    b. Commissioner Lyon mused that care coordination by way of an ADT message would still be desirable even if the patient self-pays. It was noted that if the patient desires it, they have the right to prevent that ADT message to the plan.
8. Commissioner Wagenknecht asked about the current percentage of unmatched messages. Mr. Pletcher did not know specifically, but that it was quite large to start. Commissioner Lee asked what the difference between provider capture of the information and state capture was. Mr. Pletcher explained that, in the former case, providers can close care loops.

   a. Commissioner Rinvelt asked how providers can close are loops. Mr. Pletcher answered that this activity is tied in with new payment requirements and payment models. The MiPCT project was a vehicle to begin this process.
   b. Chair Dr. Forzley added that the process requires administration, care coordinators, and other personnel. Physician Organizations have the infrastructure to do this.
9. Commissioner Lee wondered whether the ADT message would still go through MiHIN if the receiving provider were in the same HIE as the hospital in the example above. Mr. Pletcher gave an example below:
   a. If Dr. Smith is listed in the ADT message, the process is done. ADT Service sends Dr. Smith the message.
   b. If Dr. Smith has been associated with the patient in ACRS but is not in the message (and possibly not in the same HIE), the ADT service would go to the HPD, send the message to GLHIE for example, who would then send it to Dr. Smith.
10. Mr. Pletcher noted that MiHIN is trying to prevent unending message loops.
11. Ms. Edwards added that it would still be necessary to have the ADT message go through MiHIN in order to get the ADT message to payers and Behavioral Health providers.
12. Chair Dr. Forzley noted that this could be thought of as a divided Use Case: Payers need the information, and clinicians need the information, depending on attribution information given. There may be attribution issues as well.
13. Commissioner Lee asked what the information flow would be in the case of a VQO like Carebridge. Mr. Pletcher responded that the flow of the ADT message would be: Hospital to its HIE QO to MiHIN to CareBridge to the appropriate provider organization.
14. Chair Dr. Forzley reminded everyone of the long history between MiHIN and the HIT Commission. He asked if it would be possible to provide an update on the MiHIN Strategic plan for the 3-year anniversary in Q1 of 2014. Mr. Pletcher said that MiHIN would provide a summary of ONC grant activities as well.

G. HITC Next Steps

1. Ms. Vanderstelt will direct all e-mail related to the consent management discussion to the MiHIN MOAC Privacy Workgroup for follow-up comments.
2. The October Meeting covers the 1 meeting per quarter mandate in the legislation.
3. The HIT Commission will take an October to February hiatus-the next meeting after October 2013 will be in 2014.
4. Proposed Agenda:
   a. Beacon Update (nearing end of grant period)
   b. Consent discussion
   c. Planning purposes (strategic purposes)
   d. New Operating principles/roles/responsibilities
   e. Annual Report 2013
5. Chair Dr. Forzley asked all commissioners to think about their availability for attendance to facilitate 2014 planning. For the time being, the Commission will continue to plan on meeting at Capitol View the 3rd Thursday of the month. He instructed Commissioners to advise the group if schedules were to change.